**Before the**
**Federal Communications Commission**
**Washington, D.C. 20554**

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| In the Matter of: | |
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| Notice of Proposed Rulemaking (NPRM) | ) WC Docket No. 02-60 |
| Regarding the Universal Service Support Mechanism | ) DA 12-1166 |
| For Rural Healthcare | ) |

August 23, 2012

**Further Comments by the American Telemedicine Association on Issues in the Rural Health Care Reform Proceeding**

The American Telemedicine Association (ATA) is pleased to respond to the request for additional comments on the above-referenced Notice of Proposed Rulemaking (NPRM) regarding the Universal Service Support Mechanism for Rural Healthcare. While the original NPRM is now over two years old, we are encouraged by the renewed enthusiasm expressed by several Commissioners and the FCC staff to finally make needed changes in this program. Therefore, we still believe the Commission has a golden opportunity to set a new course and use this program to help fulfill goals set forth in the 2010 National Broadband Plan and achieve national needs for transforming healthcare delivery.

But this will not happen until the Commission recognizes the missed opportunities and fundamental problems of a broken program. ATA's members include almost all of the participants of the Rural Health Pilot Program and rural health support mechanism since its start 16 years ago. We can attest that, although the dollars actually spent for the original support mechanism are few, they have been useful to those health facilities lucky enough to participate. In contrast, the Rural Health Pilot Program has been fraught with multiple problems from its start. The U.S. Government Accountability Office pointed out many such concerns almost two years ago in its report, *FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program*. The Commission has yet to implement any of the GAO's major recommendations.

We also note that the just released report by the Wireline Competition Bureau staff on the Rural Health Care Pilot Program identified opportunities for and value of telehealth and went on to deem the Pilot Program a success. Unfortunately, there were two glaring deficiencies in the report and its ensuing media coverage:

- The successes of telemedicine that were identified in the report were largely despite, rather than because of, the Rural Pilot Program and its administration by the FCC and USAC, and
- The missed opportunities of the program have been far greater than the enumerated successes.

Since the 2010 NPRM, the environment for telehealth has changed dramatically. Patients, providers, and payors have increasing interest in using telehealth to reduce costs and improve the productivity of scarce health resources. Notably four more states this year have enacted legislation requiring private health plans to treat covered services provided by telehealth the same as in-person services. Additionally, almost all major health plans are investing in the use of telemedicine to provide online services and remote monitoring for covered populations. The use of mobile technology and web-based services by health providers and consumers to access health information and services has risen dramatically in those geographic areas with the capacity to provide broadband wired and wireless connectivity.

Increasingly, access to healthcare is measured as much by access to broadband as proximity to a hospital. As a result, gaps in the availability of broadband services have actually expanded the chasm of healthcare between the haves and the have-nots. Overcoming this growing disparity is the great challenge facing the FCC.

The original estimate for disbursements of Universal Service funds for the rural healthcare program was $400 million per year or $550 million in today's dollars. However, the actual disbursements in 2011 were only $81.5 million according to USAC. In contrast, actual disbursements last year for the other three components of Universal Service programs - High Cost, Lifeline and Schools and Libraries, range from $1.75 billion to $4 billion. The disparity between the original estimate and current actual disbursements and between the healthcare program and the other universal service programs are concerning.

The most important task before the Commission is to finalize the 2010 rulemaking before the end of 2012. We suggest that the initial goal of the revised program should be to triple the USF disbursements in the first year. Although a dramatic improvement, this funding would still be far less than original projections. To accomplish this, we recommend the funding process be much less prescriptive for applicants and much more competitive for awards. To be less prescriptive we recommend paperwork and reporting requirements slashed to essentials and use of the broadest conceivable definition of rural for those aspects so restricted by statute. For example, using TRICARE's definition of rural would immediately double the eligible population and other federal agencies are better able to document the utilization and economic benefits of telehealth than the FCC, USAC and its individual awardees.

The latest request from the FCC for additional comments on the program contains over 60 questions for respondents to answer about various details in the program and the original NPRM. Rather than addressing the many very narrow questions in the Commission's additional request for information, it is useful to summarize our earlier suggestions.

In our original comments on the NPRM we suggested that the Commission retarget the proposed $100 million Health Infrastructure Program away from construction toward other infrastructure costs associated with the Rural Healthcare Support and Health Broadband Services Programs. This would

avoid duplicating other federal programs and better target the use of these healthcare funds for healthcare services. We proposed that the existing Rural Healthcare Support program continue to target the most rural health facilities that are faced with extreme costs for broadband services in conformance with Section 254(h)(1) of the Telecommunications Act but suggested several enhancements to the program dealing with eligibility, grandfathering and the application process. We also suggested that the proposed expanded Health Broadband Services Program be available to all healthcare facilities not participating in the rural health care support program and should not be tied to a geographic definition.

In our subsequent reply comments we added that "Providing discounted broadband services but not adequately supporting the costs of installation or related equipment to connect to the network is tantamount to building a highway with no on or off ramps." Our other comments included:

- Wireless networks are cost effective for network deployment and health facilities and therefore health care facilities should be allowed to use both programs to purchase end-point wireless connectivity as part of the related telecommunications equipment.

- Leasing dark fiber should be allowed as an expense but the owner of the fiber then be required to meet universal service fund requirements.

- EMS provider facilities should be an eligible provider.

- Discounts for eligible services should be clarified, increased and better aligned.

We are concerned that problems in the rural health mechanism and Pilot Program may be systemic - growing out of the original design and administration of the program. To fulfill the promise and potential of this program we recommend that the Commission consider more sweeping changes that include moving the program out of its current administrative structure and, instead, employ a partnering arrangement with other government programs that will ensure coordination, take advantage of their expertise in healthcare and knowledge of how this program can best be used on the local level. Two suggestions:

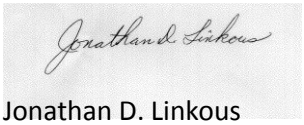
- Transfer all or a portion of the administration and operation of the program to a federal agency with experience in healthcare and managing local assistance programs. The most likely agency would be the Health Resources and Services Administration in the Department of Health and Human Services although programs operated in the Departments of Agriculture or Commerce may be good alternatives.

- Operate the program in conjunction with state health and public service agencies, perhaps providing flexibility in how the states choose to use the funds.

In conclusion, over the past two years ATA has not been shy in expressing its disappointment over the implementation of this program, but that is only because we see the potential it has to directly improve the lives of so many Americans. We remain cautiously hopeful that the current Commission and staff will take bold action to set this program on the right path before the end of 2012.

Looking ahead, the Commission and relevant Congressional committees should next reassess the overall purposes and provision of broadband needs for 1) getting health care services to all Americans wherever they are and 2) for their providers to have quick access to needed medical records for emergency to routine care. For example, we are proposing that Congress expand the program including other eligible providers under Section 254(h)(7).

Respectfully submitted,



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